



CHAPTER 9

GOAL 4: Increase the relevance, effectiveness, and accessibility of training and education.

Throughout this planning process, all types of stakeholders expressed major concerns about the nature of training and education currently offered to the workforce. In virtually every setting in which the Coalition sought input for the Action Plan, three themes resounded: the content of current training and education offerings often is not relevant to contemporary practice; teaching methods are ineffective in changing the actual practice patterns of the workers being trained; and access to training and education is often quite limited, particularly in rural communities and for culturally diverse populations. The concerns applied to preservice professional training, the initial training offered to direct care paraprofessional staff, and the continuing education of all members of the workforce. The concerns were not specific to a particular sector of the field or discipline, but were described as generally applicable to the field as a whole. There also were many concerns about the absence of educational supports for persons in recovery, children, youth, and families. These issues have been addressed explicitly under Goal 1 (Chapter 6) and are not repeated below.

National Concerns about Health Professions Education

Concerns about the current state of education and training are not peculiar to behavioral health. Nationally, there has been widespread unease about the education of the general health care workforce. The IOM, in its seminal report *Crossing the Quality Chasm* (IOM, 2001), noted the dramatic changes in service delivery in the United States that require new skills among those working in delivery systems. The changes include the shift in emphasis from acute care to chronic care, the rapidly expanding evidence base, the increasing use of team-based and other complex service delivery structures, and more collaborative patient-clinician relationships. The report further noted that the basic approach to health care education has not been revamped since 1910 in response to the issuance of the Flexner Report on medical education (Flexner, 1910). The static nature of health care education is of major concern to medical school deans, three quarters of whom acknowledge that fundamental change in the current approach to medical education is required.

To stimulate needed reforms, the IOM subsequently convened a committee and a national, multidisciplinary summit on education. The final report from this process, titled *Health Professions Education: A Bridge to Quality* (IOM, 2003), offered a vision for workforce education to support 21st century health care systems:

All health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches, and informatics. (p. 3).

The authors of the IOM report argued for a training focus on the five core competencies that are embedded in this vision. They suggested that change within educational systems be leveraged by working with the oversight organizations that accredit, certify, and license training programs, service programs, and individual practitioners.

Issues Surrounding Behavioral Health Education & Training

Graduate education has been the cornerstone of professional workforce development in mental health and, increasingly, in the addictions sector. There is a strong foundation to graduate education, derived from nearly a century of educational experience. However, there is a widely held perception that graduate training has not kept pace with recent changes in the field, producing a “training gap” (Borus, 1994; Brooks & Riley, 1996; Feldman & Goldman, 1997; Hoge, 2002; Hoge, Jacobs & Belitsky, 2000; Hoge, Jacobs, Belitsky, & Migdole, 2002; Lewis & Blotcky, 1993; Meyer & McLaughlin, 1998; Morris & Hanley, 2001; Raskin & Blome, 1998; Sabin, 1991; Sabin & Borus, 1992; Strom-Gottfried, 1997; Stuart, 2001).

Despite the fact that most graduate training occurs in academic settings, it is ironic that this training often is inadequately grounded in the scientific evidence base regarding prevention and treatment. Evidence-based practice is the conscientious, explicit, and judicious use of the best evidence gained from systematic research for the purpose of making informed decisions about the care of individuals (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996). It blends a practitioner's clinical expertise with the best available research evidence. It is also a method of self-directed, career-long learning in which the clinician continually seeks the best possible health outcomes and implements effective interventions based on the most current research evidence. Such evidence reflects verifiable, replicable facts and relationships that have been exposed to stringent scientific criteria. This research has less potential for bias than other bases for practice, in particular, the traditional “that’s how we’ve always done it” basis for practice.

It is important to remember, however, that not all clinical practice is based on science. Many aspects will not or cannot be adequately tested empirically. Furthermore, clinical acumen or intuition is important, particularly with respect to certain clinical situations in which scientific inquiry may be unable to give clear guidance on the variables related to clinical decisions. In these cases, the judgment developed from experience is even more essential. Finally, new ways of thinking take the field beyond evidence-based practice. It has been suggested that there is evidence-supported, evidence-informed, and evidence-suggested practice, as well as evidence-based practice.

The explosion of knowledge in the field makes it difficult for educational programs to remain current. The gap in knowledge and practice is exacerbated by the slow evolution of curricula in academia and the reluctance in many professional programs to train students in evidence-based or empirically validated treatments (Crits-Christoph, Chambless, Frank, Brody, & Karp, 1995). For example, a recent survey by Weissman and colleagues found that 67% of doctoral-level clinical psychology programs and 62% of social work programs did not require didactic and clinical supervision in any evidence-based psychotherapy (Weissman et al., in press). Similarly, practice guidelines, which draw on expert opinion to translate the evidence base into practical recommendations regarding treatment options, appear not to be used or taught widely in course work, supervision, and clinical placements (Yager, Zarin, Pincus & McIntyre, 1997).

Graduate programs have been slow to respond to numerous critical trends in practice, such as shared decision-making with persons in recovery, youth, and families; prevention, rehabilitation, and resilience- and recovery-oriented approaches to care; peer support; outreach; home-based services; systems of care, managed care; and patient safety. Training continues to be conducted in disciplinary silos, despite the fact that there is an emphasis in the field on interdisciplinary team-based practice, a substantive literature on inter-professional education, and historical attempts to promote interprofessional collaboration (American Psychological Association Office of Rural Health, 1995; Casto & Julia, 1994; Richards, 1996; Zlotnik et al., 1999). Perhaps most distressing is that among graduate programs focused principally on mental health, few are providing adequate training on substance use and co-occurring disorders, despite the overwhelming evidence of the prevalence of these conditions and the frequency with which individuals with such conditions seek help from mental health practitioners (Harwood, Kowalski, & Ameen, 2004).

As a consequence of the slow response of academia to the changing health care environment, the leaders of provider organizations that employ the workforce almost universally view new graduates as ill prepared for critical aspects of practice (Blumenthal, Gokhale Campbell, & Weissman, 2001; Shueman &

Shore, 1997). This makes the transition from training to practice particularly difficult for the new graduate and the employer (Gabbard, 1992), with an estimated 2 years of post training experience required to develop the requisite knowledge and skills (Blumenthal & Their, 1996).

There are many dedicated faculty in academic settings, but it is important to note that they are seldom rewarded for excellence in teaching and frequently are not even compensated for their educational activities. Many faculty report feeling constrained by the discipline-based training accreditation standards, which are slow to evolve and tend to be highly prescriptive in the areas of training content and required training experiences. Faculty efforts at reform are further hampered because training is often embedded in complex and highly bureaucratic university and health system settings, which also are slow to change. Support and development of faculty and educators remain critical areas of need if workforce development in the behavioral health field is to advance. The work on interdisciplinary faculty development in addictions through Project Mainstream, administered by the Association for Medical Education and Research in Substance Abuse (AMERSA at <http://www.amersa.org>) and supported by the Health Research and Services Administration (HRSA) and CSAT, is one exceptional model that should be studied and emulated by other sectors of the field (Haack & Adger, 2002).

Beyond the many issues surrounding graduate education and faculty development are other daunting training problems in behavioral health. Large portions of the direct care workforce are not graduate-level prepared, and yet these workers receive little substantive orientation or training about behavioral health problems and their treatment. Of further concern is that continuing education for all segments of the workforce tends to rely on single-session, didactic approaches which have proven ineffective in changing workforce practice patterns. Finally, the positive effects of training too often are thwarted when the environment in which the trainee works fails to support or perhaps even hinders the use of newly learned skills. Each of these critical issues is addressed in the context of a series of objectives and actions designed to strengthen workforce training and education.

Objective 1: Identify core competencies and focused competencies for behavioral health practice.

Competency identification, development, and assessment are getting increasing attention in all areas of health care, including behavioral health. This trend is driven by the compelling notion that, for a field to advance, there must be more precision in specifying the optimal attitudes, knowledge, and skills of the workforce. Once those competencies have been identified, the objective is to build them into the workforce and to demonstrate, using various assessment strategies, that the competencies have been acquired by individual health care providers.

In May of 2004, the Annapolis Coalition convened an expert panel on competencies as a national consensus conference (Hoge, Morris, & Paris, 2005). Experts who were developing competencies in 13 sectors of the behavioral health field met to report on their work and to learn from each other (Hoge, Paris et al., 2005). It became clear that many initiatives were underway to identify competencies and to develop comprehensive competency models and assessment strategies. It was also clear, however, that the initiatives largely were occurring in isolation, without benefit of the knowledge of competencies emerging in other disciplines or sectors of the field. For example, an extensive planning process on competency identification in one discipline reportedly occurred without any discussion of competencies being developed related to recovery- and resilience-oriented practice.

Recommendations from the consensus conference included a call for the establishment of a Competency Collaborative that would link multiple groups and organizations developing behavioral health competencies. Each group would retain independence in its work, but substantial benefits and efficiencies would accrue from the collaboration with other groups. As outlined in the conference recommendations, members of the proposed collaborative could be linked electronically and through periodic meetings to accomplish the following tasks:

- Share information regarding ongoing efforts to develop and employ competency models and to assess competence;
- assemble key resources on competency development and assessment and make these readily accessible to individual and organizational members of the collaborative;
- identify common, core, or cross-cutting competencies and competency domains;
- consider cooperative endeavors to develop and implement core competency models and assessment strategies or to jointly acquire technical assistance;
- review the relevance of competencies identified by one sector of the field (e.g., substance use disorders) for other groups and organizations that are developing competency models;
- identify areas where new competencies are needed, such as those related to patient advocacy, working in interdisciplinary teams, and informatics;
- cross-walk existing and emerging competency models to promote further development of competencies for treating individuals with co-occurring mental illnesses and substance use disorders;
- identify and disseminate case examples of successful efforts to identify and assess competencies; and
- communicate collectively and formally with professional associations, state departments of health, accrediting organizations, and other relevant bodies to inform them of available

competency models, and promote the adoption of these competencies in training, certification, and licensing processes.

(p. 660; Hoge, Morris, Daniels, et al., 2005)

One of the greatest frustrations among the experts who are developing competencies is the slow adoption of this work in training programs. The proposed Competency Collaborative could serve a critical dissemination function as its members worked together to leverage more rapid adoption of competencies and competency assessment. The collaborative also could provide faculty development in the integration of these competencies in curricula and clinical training programs. Finally, the collaborative could develop consensus standards for evaluating competency models and competency assessment procedures both on rigor and relevance to contemporary practice.

The substance use disorders treatment field has pioneered work on core competencies for addiction counseling through the development of Technical Assistance Publication (TAP) Series 21 (DHHS, 1998). This work has been extraordinarily well received, translated into multiple languages, and adopted as a focus of training and certification in numerous countries around the world. In contrast, a widely recognized set of core competencies for mental health practice simply does not exist. While many of the mental health professions are developing their own competencies, there are many high-school-, associate's-, or bachelor's-degreed members of the workforce for whom a well-developed competency model is not available and for whom competency-based training is seldom provided.

The Annapolis Coalition strongly recommends that a set of core competencies for mental health practice be developed. Senior advisors to the Coalition on substance use disorders recommended that this effort use the TAP 21 addiction counseling competencies as a base of departure. The work could be further informed by competencies sponsored by the Center for Mental Health Services (CMHS) for practice in managed care environments (e.g., Coursey et al., 2000a; Coursey et al., 2000b; <http://www.uphs.upenn.edu/cmhpsr/cmhs>) and by the training models developed by organizations such as the Center for Psychiatric Rehabilitation at Boston University (<http://www.bu.edu/cpr>). The core competencies should include basic skills related to the assessment and treatment of substance use disorders and co-occurring mental and addictive disorders.

Some efforts have been made to develop specialty competencies related to the care of children and adolescents, older persons, and other populations and specialty sectors (Hoge, Paris, et al., 2005). The locus of continued activity on competency development in these areas must be identified and adequate funding must be provided to support the continued work. In addition, concerted, systematic attention is needed to ensure that competencies are developed in such specific and critical practices as: person-

centered planning; culturally competent care; development of therapeutic alliances; shared decision-making; prevention, routine use of evidence-based practices; recovery- and resiliency-oriented care; rehabilitation; interdisciplinary and team-based practice; advocacy, use of informatics; and continuous quality improvement.

Objective 2: Develop and implement competency-based curricula.

An obvious corollary to the development of the competencies is to design and implement curricula that are competency based. One area of urgent need is to develop a competency-based, portable curriculum for entry-level, direct care staff in settings where individuals with mental illnesses and co-occurring mental and addictive disorders receive services. Despite the fact that these staff members are often the primary caregivers in many publicly funded programs, it appears that, across the nation, they receive little substantive training. To the extent that states and provider organizations are attempting to educate this critical segment of the workforce, they appear to be cobbling together homegrown curricula and relying on brief didactic orientation programs that are highly unlikely to build competency in core skill areas.

The Annapolis Coalition recommends that a panel of experts be convened to guide the development of competency-based curriculum for this segment of the workforce. The curriculum should be field-tested, finalized, and made broadly available to states and service organizations at low cost or no cost. While core competencies are more developed in the addiction sector of the field (DHHS, 1998), existing curricula based on those competencies similarly should be identified, reviewed, strengthened if necessary, and broadly disseminated.

The locus of competency-based curriculum development in all specialty sectors of the field needs to be identified, and efforts to do so should be supported and advanced. The field lacks a set of consensus standards for evaluating the quality of curricula, and the proposed Competency Collaborative would be capable of developing such standards, in consultation with other groups and organizations. Most critically, education and training program administrators must speed the process of curriculum reform by reviewing and updating their curricula biannually. To create transparency in this process, the Coalition recommends that all education and training program administrators evaluate the relevance and effectiveness of their curricula and make these assessments available to prospective and current students, persons in recovery, youth, family members, advocates, and the general public.

Objective 3: Adopt evidence-based training methods that have been demonstrated as effective through research.

It is common to discuss the evidence base for prevention and treatment interventions, but the field has paid less attention to the evidence base for teaching methods. There is a solid evidence base in medicine regarding effective and ineffective teaching and skill development approaches (Davis et al., 1999). The core finding in this literature is that didactic, single-session, noninteractive teaching approaches may increase knowledge, but are ineffective in building skills among trainees (Mazmanian & Davis, 2002). Unfortunately, it is the didactic, single-session approach that predominates in continuing education and is quite prominent in preservice education as well. Thus, enormous amounts of training time and resources likely are being squandered. The data on this issue are so consistent that Davis and his colleagues (1999) concluded that continuing education credit should probably not be offered for most continuing education events.

There is a growing body of evidence on effective teaching practices that produce behavior changes among learners (Stuart, Tondora, & Hoge, 2004). To be effective in building skills, it is necessary to combine multiple teaching strategies as there is no single “magic bullet” (Oxman, Thomson O’Brien, Davis, & Haynes, 1995). Strategies that have proven effective are: interactive approaches; sequenced, longitudinal learning experiences; outreach visits, known as academic detailing; auditing of practice with feedback to the learner; reminders; the use of opinion leaders to influence practice; and patient-mediated interventions, such as providing information on treatment options to persons in recovery, which in turn influences the practice patterns of their providers (Borgiel et al., 1999; Davis et al., 1999; Soumerai, 1998; Thomson O’Brien et al., 2003).

The evidence on effective teaching strategies is evolving rapidly and it is imperative that this knowledge base have an impact on current training practices. This will require focused faculty development initiatives. To achieve this objective within behavioral health, the Annapolis Coalition recommends that an expert, multidisciplinary panel of educators be convened to review, summarize, and disseminate the evidence on effective teaching approaches. The panel, with assistance from the proposed National Technical Assistance Structure, should also develop an evaluation tool for use by training and education organizations to conduct self-assessments of their teaching practices. The results of these evaluations should be made available to the public, just as the self-evaluations of curricula are. Because educational practices are largely driven by accreditation standards and processes (IOM, 2003), it is imperative that these standards be modified to require the use of evidence-based teaching approaches in both preservice and continuing education.

Enormous amounts of training resources in behavioral health are invested in conferences and meetings, supported by state and federal resources or financed as fee-based continuing education events. Given the research findings on effective teaching and learning strategies, there is little reason to believe that the conference model leads individual participants to change their practice patterns or other professional behaviors. Furthermore, the noneducational objectives and outcomes of these large meetings often seem unclear.

As a first step in addressing the issue of adapting evidence-based training methods that research has shown to be effective, the Annapolis Coalition recommends that the proposed panel in effective education develop and disseminate technical assistance on alternative conference and meeting models. The organizers of the meetings are responsible for adopting more effective approaches to such gatherings. The funders of such meetings, including federal and state agencies and professional associations, should require the use of effective teaching models and demonstrated outcomes as a condition of financial support.

Objective 4: Use technology to increase access to and the effectiveness of training and education.

Clearly, major advances in the use of technology to support teaching and learning have occurred. A virtual explosion in the use of computer-assisted and Web-based instruction has provided greater access to curricula. Less evident is the effectiveness of these methods in teaching clinical skills. Critical questions remain about the key elements that must accompany technology-assisted instruction, such as supervised experience and mentoring, for these electronic methods of educational delivery to be effective for clinicians.

Given the promise of technology as a vehicle of workforce training and development, the Annapolis Coalition recommends that the evidence-based and best practices in this arena be summarized and broadly disseminated to the field. Widespread implementation of these best practices will require funding of demonstration programs as organizations adopt and adapt new technologies to behavioral health. As educators self-assess their use of effective teaching practices, so too should they evaluate whether their technology-assisted teaching approaches are supported by research evidence.

Objective 5: Launch a national initiative to ensure that every member of the behavioral health workforce develops basic competencies in the assessment and treatment of substance use disorders and co-occurring mental and addictive disorders.

Nearly 22 million persons ages 12 and older, totaling 9.4% of the U.S. population, are dependent on or abuse alcohol or illicit drugs. Only 1 person in 10 with a drug use disorder and 1 person in 20 with an alcohol use disorder receive treatment for the condition (Wright, 2004). Furthermore, the prevalence of persons with co-occurring mental and addictive disorders has been on the rise. For example, one study found that 61% of individuals with a severe mental illness had a substance abuse or dependence problem (Jaffee, Comtois, Calsyn & Saxon, 1998).

Individuals with addictive and co-occurring mental and addictive disorders frequently seek help from members of the workforce who are trained as mental health practitioners. Research suggests that, depending on the practice setting, between 20% and 75% of persons seeking services from mental health practitioners have co-occurring disorders (Menezes et al., 1996). One review found that half of all individuals presenting with psychiatric emergencies had a substance abuse problem (McNamara, Schumacher, Milby, Wallace, & Usdan, 2001).

Unfortunately, few mental health professionals are adequately trained to address the needs of persons with substance use disorders or problems. CSAT, in collaboration with six professional associations, created the Practitioner Services Network to study this issue among association members (Harwood, Kowalski, & Ameen, 2004). The findings revealed that in private-practice settings 15% to 25% of clients presented with substance abuse problems, while in treatment facilities, the percentages ranged from 20% to 40%. Despite the prevalence of addiction problems among individuals being served, no more than half of the mental health practitioners surveyed through the Practitioner Services Network had any formal coursework or internship in addiction treatment.

The need to train professionals in the prevention, recognition, assessment, and referral to or basic treatment of persons with substance use disorders is glaring, yet little progress appears to be occurring on this agenda. As an example, a survey of 10 doctoral psychology programs by Aanavi, Taube, Ja, and Duran (1999) found that none required coursework on substance use disorders and that half offered only a single elective course on the topic. In another study, three quarters of social workers surveyed in New England indicated that they had either a moderate, significant, or maximum need for additional training in addictions (Hall, Amodeo, Shaffer, & Vander Bilt, 2000).

The obstacles to educating the mental health workforce in basic addiction-related competencies are complex. They relate to the structures and processes surrounding curriculum development, the accreditation of training and provider programs, and the certification and licensing procedures for providers. To explore and address the many obstacles, the Annapolis Coalition recommends the creation of a Commission on the Adoption of Competencies related to the treatment of substance use disorders and co-occurring mental and addictive disorders. The Commission would bring together the key organizations that govern curricula, accreditation, certification, and licensure to systematically identify and implement strategies to overcome each of the barriers that historically have hindered major progress on this agenda. The Commission would issue an annual report to the nation on the progress made on the agenda. Beyond addressing the urgent need to expand training in addictions, this process would shed light on the dynamics of change necessary to curriculum development, accreditation, certification, and licensure. It would inform future efforts to speed the translation of sciences to services in workforce development activities.

Objective 6: Educate prospective students about best practices in training and education to inform their selection of a training program or training provider.

Students are at a disadvantage as they pursue training because there are currently no tools to assist them in evaluating the quality of competing preservice and continuing education programs. The Annapolis Coalition recommends the creation, field-testing, and broad dissemination to prospective students of a guide that outlines best practices in training and education programs. The objective is to help prospective students choose training programs that have the greatest likelihood of effectively preparing them to enter the workforce with the skills required in the contemporary health care environment. A student “shopping guide” was developed and successfully implemented in primary care medicine by the Partnerships for Quality Education (<http://www.pqe.org>), which is a consortium of academic programs focused on preparing young doctors for community-based practice in a managed care environment. Helping students to become informed “purchasers” of training and education has the potential to leverage change and relevance more rapidly within behavioral health training systems.

Objective 7: Identify and implement strategies to support and sustain the use of newly acquired skills in practice settings.

There is evidence that an effectively trained provider will fail to use newly acquired skills if he or she returns to a work environment where the new skills are not understood and actively supported. Building skills and changing practice involves a combination of training and environmental change. Without attention to the work environment, training efforts will be undermined. As Geary Rummier, an expert in

human performance, has so cogently stated, “When you pit a bad system against a good performer, the system almost always wins” (Rummler, 2004).

There is a growing body of knowledge and evidence related to sustaining newly acquired skills, drawn from efforts to implement evidence-based practices (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). The Coalition recommends that experts on the environmental changes required to support new practices be convened to distill and subsequently disseminate this knowledge through the provision of technical assistance to states and organizations that employ the workforce.

Conclusion

Increasing the relevance, effectiveness, and accessibility of training and education are urgent priorities for the field of behavioral health. Achieving reform in current approaches to training and education will be an essential step in improving quality and transforming systems of care.

Continued work on competency identification and assessment will be a foundation for this work, with collaboration among the many groups and organizations that are tackling this issue for specific populations or sectors within the field. Curricula that are competency-based and delivered via instructional techniques that are evidence based are also key elements of needed reform, with greater emphasis on the use of technology to facilitate access to educational materials.

Perhaps most important, it is essential to unpack and address the roadblocks that prevent the timely updating of curricula, training programs, accreditation standards, and certification and licensure processes. These are the key elements and drivers of the education and training system. It is imperative that they become more relevant to prevention and treatment in current health care systems.

[Table 9.1: Objectives & Actions for Goal 4](#)

GOAL 4: Increase the relevance, effectiveness, and accessibility of training and education.
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Objective 1: Identify core competencies and focused competencies for behavioral health practice.

Action 1: Establish a Competency Collaborative that links organizations developing behavioral health competencies and provides technical assistance.

Action 2: Develop a model set of core mental health competencies.

Action 3: Identify and further develop specialty competencies, relevant to specific areas of behavioral health practice.

Action 4: Identify and further develop competencies in critical practices that include (a) person-centered planning, (b) culturally competent care, (c) development of therapeutic alliances, (d) shared decision-making, (e) evidence-based practice, (e) recovery- and resilience-oriented care, (f) rehabilitation, (g) interdisciplinary and team-based practice, (h) advocacy, (i) use of informatics, and (j) continuous quality improvement.

Objective 2: Develop and implement competency-based curricula.

Action 1: Develop model, portable curricula for entry-level, direct care staff based on the core competencies.

Action 2: Develop a set of consensus standards for evaluating curricula on relevance and effectiveness.

Action 3: Identify or further develop competency-based specialized curricula, relevant to specific areas of behavioral health practice.

Action 4: Require training and education organizations routinely to review and update their curricula and conduct self-evaluations using the consensus standards.

Objective 3: Adopt evidence-based training methods that have been demonstrated as effective through research.

Action 1: Identify effective teaching methods through a systematic review of available research.

Action 2: Employ evidence-based teaching methods in training and education organizations.

Action 3: Require (through accreditation standards for preservice and continuing education) the use of evidence-based teaching methods.

Action 4: Identify and adopt conference and meeting models that have demonstrated impact on participant learning and behavior.

Objective 4: Use technology to increase access to and the effectiveness of training and education

Action 1: Provide technical assistance to training and education organizations in best practices in the use of technology for learning.

Action 2: Employ best practices in the use of technology-assisted instruction.

Action 3: Fund demonstration initiatives in technology-assisted instruction.

Objective 5: Launch a national initiative to ensure that every member of the behavioral health workforce develops basic competencies in the assessment and treatment of substance use disorders and co-occurring mental and addictive disorders.

Action 1: Incorporate addiction and co-occurring competencies into all competency models, preservice and continuing education curricula, training accreditation and program accreditation standards, and certification and licensure requirements.

Action 2: Implement or expand training and staff development on the assessment and treatment of substance use disorders and co-occurring mental and addictive disorders throughout preservice and continuing education.

Objective 6: Educate prospective students about best practices in training and education to inform their selection of a training program or training provider.

Action 1: Develop and disseminate a *Guide to Selecting Relevant and Effective Training* designed for prospective students.

Objective 7: Identify and implement strategies to support and sustain the use of newly acquired skills in practice settings.

Action 1: Identify strategies proven to be effective in supporting and sustaining newly acquired skills and behavior change within organizations.

Action 2: Adopt organizational interventions to support and sustain newly acquired skills and measure sustained behavior change within the workforce.

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